

**Nurses' experiences of bedside  
handover reporting in the palliative  
care wards of hospitals and hospices**

A Literature Review

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Abstract  <p>Palliative care aims at improving the quality of life of patients and their families; it begins when a patient is diagnosed with a terminal illness and continues even after death. Relieving pain and other symptoms, enhancing the quality of life and supporting patients to live actively are the primary goals. Nursing bedside handovers take place by the patient's bedside. Bedside handovers help to reduce errors, increase patient safety and satisfaction among patients and health care professionals.</p> <p>The aim of the study was to find out nurses' experiences while giving and receiving bedside handover reports in hospital and hospice palliative care wards. The purpose was to provide information to nurses who work in hospital and hospice palliative care wards on how to develop the giving and receiving of bedside handover reports using existing evidence based research.</p> <p>Two databases, CINAHL and PubMed, were utilized for gathering relevant research articles that met the specified inclusion criteria. In total, 7 articles were chosen to be reviewed. Content analysis was applied in the analysis of the data.</p> <p>The main themes that were generated include: confidentiality, patient/carers involvement, shared decision-making, amount of time spent on bedside handovers and interruptions. The review proposed that education to improve communication and strategies that encourage family members to participate in bedside handovers need to be further investigated.</p>		
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## 1 Introduction

Palliative care regards death as a natural process. Goals for care aim at relieving pain and other symptoms, enhance the quality of life and support the patient to live as actively as possible until death. Goals for care are developed together with patients and their families. (Watson, Lucas, Hoy, & Wells 2009, 34; WHO 2017.) Palliative care services are provided in outpatient, inpatient and community outreach services. (Cameron-Taylor 2012, 2.)

Nursing handovers take place during the change of shifts (Wolf 2013, 116). Professional responsibility and accountability for patients and their care are transferred from the off-going nurses onto the on-coming nurses during handovers (Munro 2016, 58). Bedside handovers take place by the patient's bedside (Wolf 2013, 122). Patients and their families have the right to either participate or not (Munro 2016, 58). Bedside handovers provide individualized care and help to ensure patient safety (Tucker, & Fox 2014, 45).

Communication problems between healthcare professionals or with patients are a leading cause of unexpected deaths and serious physical or psychological injuries to patients (Ferrara, Terzoni, Davì, Bisesti, & Destrebecq 2017, 882). Factors that can influence communication between nurses, patients or their families during bedside handovers include confidentiality, patient/carer involvement, shared decision-making, amount of time, interruptions, among others.

This study will mainly concentrate on the experiences of nurses while giving and receiving bedside handovers in hospital and hospice palliative care wards. However, the influences of patients and their families will also be considered. This study will focus on autonomous adult patients and their families.

The aim of this thesis is to find out nurses' experiences of giving and receiving bedside handover reports in hospital and hospice palliative care wards. The purpose is to provide information to nurses who work in hospital and hospice palliative care wards on how to develop the giving and receiving of bedside handover reports using existing evidence based research.

## 2 Theoretical basis

### 2.1 Palliative care

Palliative care is an approach that improves the quality of life of patients and their families facing the problem associated with life-threatening illness, through the prevention and relief of suffering by means of early identification and impeccable assessment and treatment of pain and other problems, physical, psychosocial and spiritual (WHO 2017). According to Dos Santos, De Souza, De Scaldelai, Da Lozano, Sailer, and Preto (2017), palliative care begins when a patient is diagnosed with a terminal illness and continues even after death. Therapies and interventions that are directed at controlling symptoms and progression of the underlying illnesses are sometimes provided concurrently with palliative care. (2291.)

In palliative care, death is regarded as a natural process and the care provided neither seeks to fasten the process of dying, nor to defer death. A skilled team of healthcare professionals provide patients and their families with the support they need to understand the disease as it progresses and the concept of death. Goals for the care are developed together with patients and their families. These goals aim at relieving pain and other symptoms that develop as illnesses progress, enhance the quality of life, and support the patient to live as actively as possible until death. In addition to healthcare professionals, the clergy and members of the community provide physical, psychological and spiritual support in the care for patients and their families. When a loved one dies, family members are provided with support during the bereavement process, as appropriate. (Watson et al. 2009, 34; WHO 2017.)

Figure 1 below shows the sites where palliative care services are provided in the society. These include outpatient, inpatient and community outreach services. Outpatient palliative care is provided in a range of settings such as in hospices, in residential homes, in day care services and in long term care facilities. Inpatient palliative care is organized in hospitals and health centres. (Cameron-Taylor 2012, 2–4.) A specialist group consisting of doctors, nurses, allied health professionals and social workers work together with patients and their families in palliative care wards in hospitals and hospices. These professionals provide evidence-based physical,

emotional, psychosocial, and spiritual needs to patients and their families. (Matzo, & Sherman 2014, 4.)

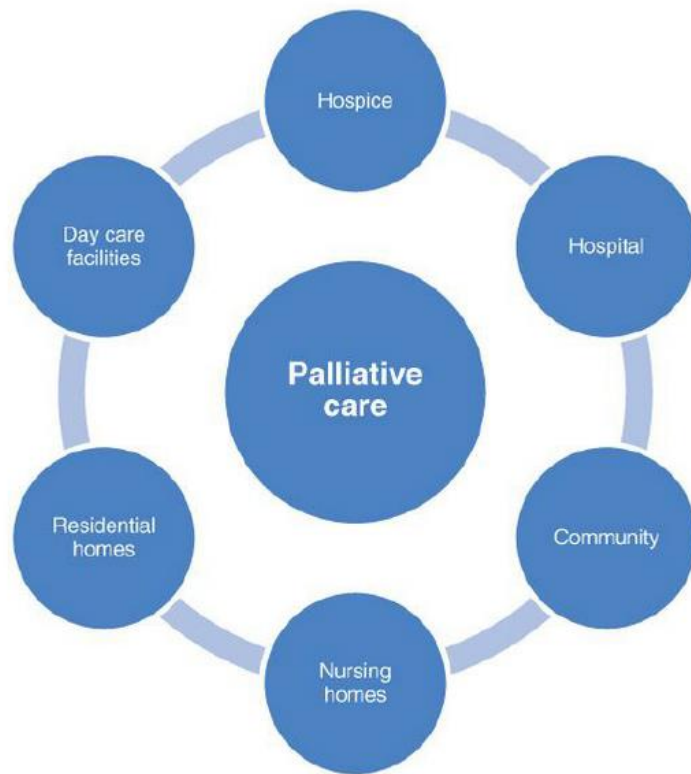


Figure 1. Sites of palliative care provision (adapted from Rosser, & Walsh 2014, 36)

Patients and their families should be cared for in an ethical manner which is in accordance with their wishes. Palliative care nurses need to ensure collaborative practices amongst the healthcare professionals involved in caring for patients and their families. (Matzo, & Sherman 2014, 8.)

The information and education provided to patients and their families by healthcare professionals needs to be accurate and accessible. Building and maintaining effective communication between healthcare professionals, patients and their families in the initial stages is crucial. Ineffective communication can lead to misunderstandings,

confusion, resentment, isolation and lack of cooperation. All these feelings can impact negatively on patients and their families and deny them the chance of experiencing death in a dignified and comfortable manner. (Cameron-Taylor 2012, 8.)

An autonomous patient is one who is capable of making an informed decision without coercion or manipulation by others, and informs the decision regarding the course of action for his or her care to others (Zalonis, & Slota 2014, 707). For competent patients to make informed decisions, they must be provided with accurate information regarding their condition and the available options for treatment and care. Privacy and confidentiality are key in ensuring that the information provided does not leak to unauthorized people. (Watts 2009, 24.)

The person or persons identified by the patient as their next of kin are considered as family. Even though autonomous patients can make their own decisions, healthcare professionals should involve their families in the decision-making processes. Family members or guardians of non-autonomous patients are authorized to make decisions on their behalf regarding their care. The involvement of the patient's next of kin should be clearly documented, whether or not they are required to give consent. (Qasim, Oyekan, Boyd, Kieffer, & Panose 2016, 148.)

## 2.2 Communication between nurses and with patients and their families in hospital and hospice palliative care wards

Effective communication between nurses, patients and their families is the cornerstone in building therapeutic relationships and can be achieved during the first meeting though it requires that nurses are tactful during communication. Communication with patients and their families should be conducted in a respectful and empathetic manner. (Campbell 2012, 7.)

When a person is diagnosed with a terminal illness and must face the prospect of death, feelings of anger, fear, frustration and despair may arise. Patients and their families often rely on nurses to provide physical, emotional, psychological and spiritual support during these distressing times. Communicating in an honest and



sensitive manner with patients and their families helps to build and maintain therapeutic relationships which are based on trust. (Wild, Peate, & Nair 2014, 421.)

Rosser and Walsh (2014, 195) state that palliative care aims at providing patient-centred care. Patients and their families are the unit of care and therefore palliative care nurses should view them as individuals and identify their own needs, goals and expectations for treatment and care. Active listening by nurses is an important skill which enables them to interpret both verbal and non-verbal communication. The information provided by patients and their families should be handled with care and confidentiality (Matzo, & Sherman 2014, 7). Ferrara and colleagues (2017, 885) state that effective communication contributes to the willingness of patients to adhere to the care and interventions provided to them, and enables nurses to achieve the planned outcomes.

Problems in communication between healthcare professionals and with patients have been sighted as one of the causes of unexpected deaths and serious physical or psychological injuries to patients in healthcare settings (Ferrara et al. 2017, 882). According to Bruton, Norton, Smyth, Ward, and Day (2016, 386), poor communication also undermines patients' and healthcare professionals' experiences. There are several factors that can influence communication between nurses or with patients, or their families.

According to Watson and colleagues, evidence shows that as few as 40% of patients disclose their concerns to healthcare professionals. The most anxious and distressed patients are least likely to disclose their concerns. Some reasons why patients fail to disclose their concerns include their inability to cope with the circumstances, fear that they will lose control in front of strangers, fear of being stigmatized if they admit to having psychological problems and fear of having their worst concerns being confirmed. Some patients feel that healthcare professionals sometimes fail to ask the relevant questions, or that they are too busy to discuss about their concerns with them. Others believe that their concerns are insignificant, or that their concerns will only increase the burden for healthcare professionals. (Watson et al. 2009, 67–68.)

On the other hand, palliative care nurses may experience fears of being asked unanswerable questions, saying the wrong thing, upsetting and unleashing strong

emotions and dealing with patients' and their families' strong reactions. They may also face uncertainties on how to break bad news, handle anger or denial among patients and their families. Sometimes, palliative care nurses may also feel that they lack enough support from their colleagues or their superiors. (Watson et al. 2009, 66–67.)

Communication is greatly affected by the environment in which it occurs. Ideally, communication between nurses, and with patients and their families should take place in a quiet and comfortable place. (Rosser, & Walsh 2014, 222.) Hospitals and hospices are public places which are often very busy. It can sometimes be very challenging to provide a private and comfortable environment to carry out discussions between nurses and with patients and their families. (Farrington, & Townsend 2014, 773.) Emergencies, noise from machines, telephone calls and interruptions from other nurses, patients or visitors are common. These interruptions can cause poor concentration, leading to misunderstandings and errors occurring. (Boyd, & Dare 2014, 53.)

According to Croos (2014, 735), performing nurse-to-nurse handovers is not taught formally in many nursing schools, which raises the question of the ability for inexperienced nurses to communicate effectively during their working life. Lack of adequate communication skills can lead to misunderstandings and cause vital information to be omitted (Ferrara et al. 2017, 882). Nurses' inexperience and lack of confidence can lead to them feeling intimidated to carry out bedside handovers; some nurses may fail to engage patients in the discussion altogether. In addition, it can lead to patients feeling insecure about their care. Providing relevant training to nurses can help them to gain confidence and improve their competency in carrying out bedside handovers. (Bruton et al. 2016, 389–392.)

Bruton and others state that nursing handover reports should be carried out in a standardised, structured, and systematic order (Bruton et al. 2016, 392). According to Croos (2014), structured handovers provide accuracy and clarity (736). ISBAR, an acronym that stands for Identify, Situation, Background, Assessment, and Recommendation, Read-back, Risk, is a tool for communication that has been adapted in many hospitals and care facilities as the standard format for nursing handovers (Munro 2016, 58–59).

According to Watson and colleagues, ward nurses spend an average of three minutes in a shift tending to patients' psychological care (Watson et al. 2009, 796). Sonntag, McGregor, Plebani, Della, Jones, Steward-Wynne, Walsh, Cominos, Jureidini, and Pirone state that for communication between nurses, patients and their families to be effective, all the relevant participants should be present and that they should allocate enough time for the discussion. If some of the participants are missing, their views might not be fully represented, and they might not receive all the information that is discussed. If too little time is allocated for discussions, communication tends to be rushed and essential information could be left out. (Sonntag et al. 2016, 8.) People receive and process information in varying ways, therefore healthcare professionals should break bad news to patients and their families in a sensitive manner and allow them time to process the information and ask questions. Delivering bad news in a hurried and in an unsympathetic manner can lead to patients and their families, especially those who are in denial, to misinterpret or forget what was said. (Watson et al. 2009, 69.)

Sometimes, patients may wish to have some, or all their information remain confidential from their families. Confidential information may include test results, communicable diseases, domestic violence, elder abuse and do-not-resuscitate (DNR) orders. The more public the environment in which nursing handovers take place, the greater the risk of breaching confidentiality of patient information. (Starr 2014, 21.)

It is widespread practice for health care professionals to use clinical jargon, abbreviations and acronyms while communicating and documenting patient information. Rees (2013) states that this practice has been widely criticized as it disguises the meanings of words thereby making it difficult for people outside the health care profession to understand. The practice has also been sighted as an obstacle to effective communication especially among less experienced health care professionals. (28.) The use of abbreviations, complicated jargon or acronyms should be avoided as it can lead to misunderstandings between nurses, patients and their families (Boyd, & Dare 2014, 63).

## 2.3 Nursing handover reports

According to Wolf (2013), nursing handover reports take place during the change of shifts, where the off-going nurses provide the on-coming nurses with information regarding the condition and the care given to patients and their families. Nursing handover reports are often conducted on a one-to-one basis, or in a group setting and are often carried out at ward offices, nurses' stations, along corridors, at patients' bedsides or in halls. (119–122.) All nurses have a duty to ensure that they communicate effectively with their colleagues about all the patients under their care and they should provide the relevant information regarding their care (Tucker, & Fox 2014, 44).

During nursing handover reports, professional responsibility and accountability for patients and their care are transferred from the off-going nurses onto the on-coming nurses (Munro 2016, 58). Handover reports serve as learning experiences for nursing staff and students and provide them with opportunities to clarify unclear information. Errors and risks to either the patients or healthcare professionals are discussed during handovers, in a bid to reduce or eliminate them. Allocation of nurses to patients, identification of the charge nurse, as well as the organization of the upcoming shift are also communicated. Nurses often socialize and support each other during handover reports. Information regarding past and upcoming events is also communicated during handover reports. (Wolf 2013, 119.)

Many hospitals and healthcare facilities across the world recommend the use of ISBAR during nursing handovers. ISBAR is a communication tool that was developed to provide a guideline for healthcare professionals to communicate with each other during consultations and transfer of care for patients. ISBAR is an acronym which stands for Identify, Situation, Background, Assessment, and Recommendation, Read-back, Risk. (Munro 2016, 58–59.)

There are four main types of nursing handover reports which are namely, verbal, tape-recorded, written and bedside handovers. Verbal reports are the most favoured. (Boyd, & Dare 2014, 29–30.)

## 2.4 Bedside handover reports

Bedside handovers, also referred to as walking rounds, are a form of verbal handover reports which take place by the patient's bedside. The off-going nurse introduces the patient, and his or her family to the on-coming nurse and provides information regarding the goals and the plan of care. This allows the on-coming nurse to meet the patient and his or her family and prioritize for the shift. (Wolf 2013, 122.)

Munro (2016) states that patients and their families have the right to either participate or not during bedside handovers. Nurses need to consider the preferences of patients and their families while giving bedside handover reports and ensure that they meet the required confidentiality regulations regarding patient information. (58.)

Since patients are often involved in bedside handovers, they can communicate their needs and preferences with the on-coming nurses, which allows the on-coming nurses to plan and provide individualized care for patients and their families. Bedside handovers also provide the opportunity for patient charts and medication to be checked, which is crucial in ensuring patient safety. (Tucker, & Fox 2014, 45.)

Bedside handovers can help to reduce errors and increase patient safety, as they allow checks on patient identification and alterations in their condition to be done. When handover reports are carried out at the patient's bedsides, the patients can ask questions regarding their diagnosis and the plan of care. This helps to clarify misunderstandings for both patients and healthcare professionals. Research shows that involving patients in handovers greatly helps them to adhere to their treatment and care plans and reduces the number of hospital readmissions. When bedside handovers are conducted with skill, confidentiality and consistency, patients report having higher confidence levels in their care. (Sonntag et al. 2016, 11–12.) Croos (2014) states that according to research, nurses feel that teamwork is improved during bedside handovers, and that they receive support from senior staff members (735).

### **3 Aim, purpose and research question**

The aim of this thesis is to find out nurses' experiences while giving and receiving bedside handover reports in hospital and hospice palliative care wards.

The purpose of this thesis is to provide information to nurses who work in hospital and hospice palliative care wards on how to develop the giving and receiving of bedside handover reports using existing evidence based research.

The research question is:

What kinds of experiences do nurses have while giving and receiving bedside handover reports in hospital and hospice palliative care wards?

## 4 Methodology

### 4.1 Literature review

A literature review involves reading, assessing, analyzing and synthesizing information from previous researches that have been carried out on a certain topic to build a foundation for one's research (Wang, & Park 2015, 59). Carrying out a literature review provides information on what has already been done, and helps to identify where the gaps lie in research (Williamson 2002, 49). The information that is utilized while carrying out literature reviews can be obtained from a range of sources which include books, academic articles, journals, reports, theses and conference papers (Williamson 2002, 61). Literature reviews are not based merely on summarizing the findings of previously carried out researches, but rather, involve critical reflection, grouping studies that are similar, and relating them to other researches (Wang, & Park 2015, 59).

There are several reasons why literature reviews are carried out. The first reason is to explore and learn how to utilize information from previous researches to build one's own research. The second reason is to find out the main theories and research methods which are related to one's topic that have been used in previous researches. In so doing, one can identify the methods that have been proven inappropriate for carrying out a similar research. Literature reviews also help to identify how research related to one's topic has changed over time and can help to point out some challenges that one might encounter while carrying out his or her own research. Lastly, one can use a literature review as a way to rationalize and justify the reason and method used for carrying out his or her research. (Wang, & Park 2015, 59–60.)

### 4.2 Conducting a literature review

Literature review is a process that is carried out in a systematic manner. Figure 2 below shows the steps that are involved in carrying out a literature review. Once the research questions have been formulated, the next step is for the researcher to create a theoretical framework on which to base his or her research. The researcher

then performs a thorough investigation of scholarly researches which are related to his or her topic. (Wang, & Park 2015, 60.)

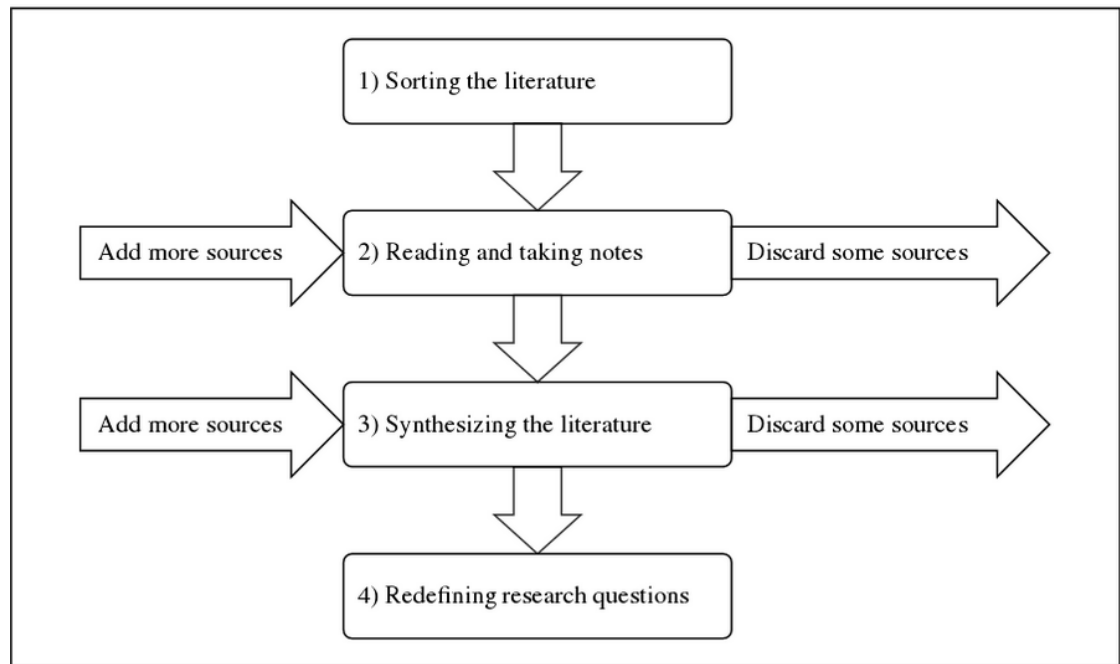


Figure 2. The process of literature review (adapted from Wang, & Park 2015, 60)

Often, the researcher will come across a vast amount of information that may or may not be related to his or her research. It is important to identify which information is relevant, and disregard that which is not. Choosing what to include or exclude from one's research may be based on the sources that are chosen from which to obtain information, research methods, similar or opposing arguments, age of the existing data or the type of research that is to be carried out. Having a clear concept of what is to be studied, and formulating some key words often helps in selecting the relevant sources from which to obtain information. Reading abstracts and subheadings of previous researches can help one to evaluate which researches are relevant to his or her topic. Analyzing, synthesizing and summarizing the results into a cohesive form then follow. (Wang, & Park 2015, 61–63.)



### 4.3 Article selection process

The two databases that were selected for searching for articles were CINAHL and PubMed. The criteria that was given for searching were that the articles had to be original research studies, peer-reviewed, written in English language and were published during the years 2005 to 2015. Figure 3 below shows the inclusion and exclusion criteria.

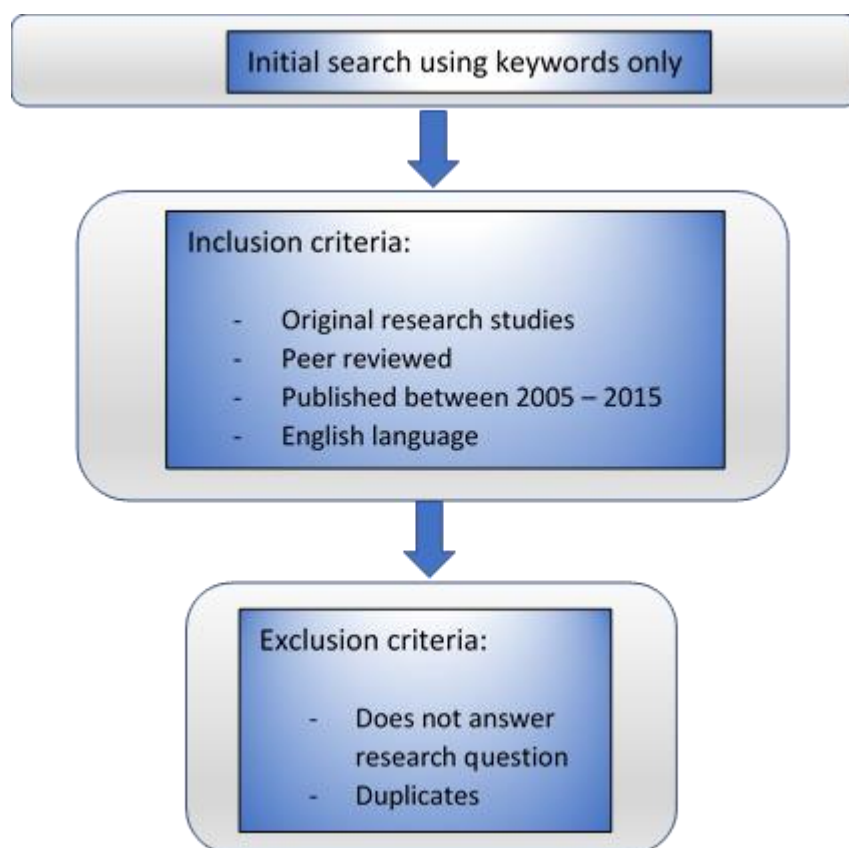


Figure 3. Inclusion and exclusion criteria

An initial search that utilized synonyms which were combined with other keywords, for example, "bedside handover" or "bedside shift report" and "hospital" was carried out in the CINAHL database. The number of articles that were relevant to these

search terms was 86. A redefined search which utilized the given search criteria was then carried out. Using the same keywords as before, and after applying these search criteria, the number of relevant articles reduced to 29. Table 1 below represents the results of the search process in numbers.

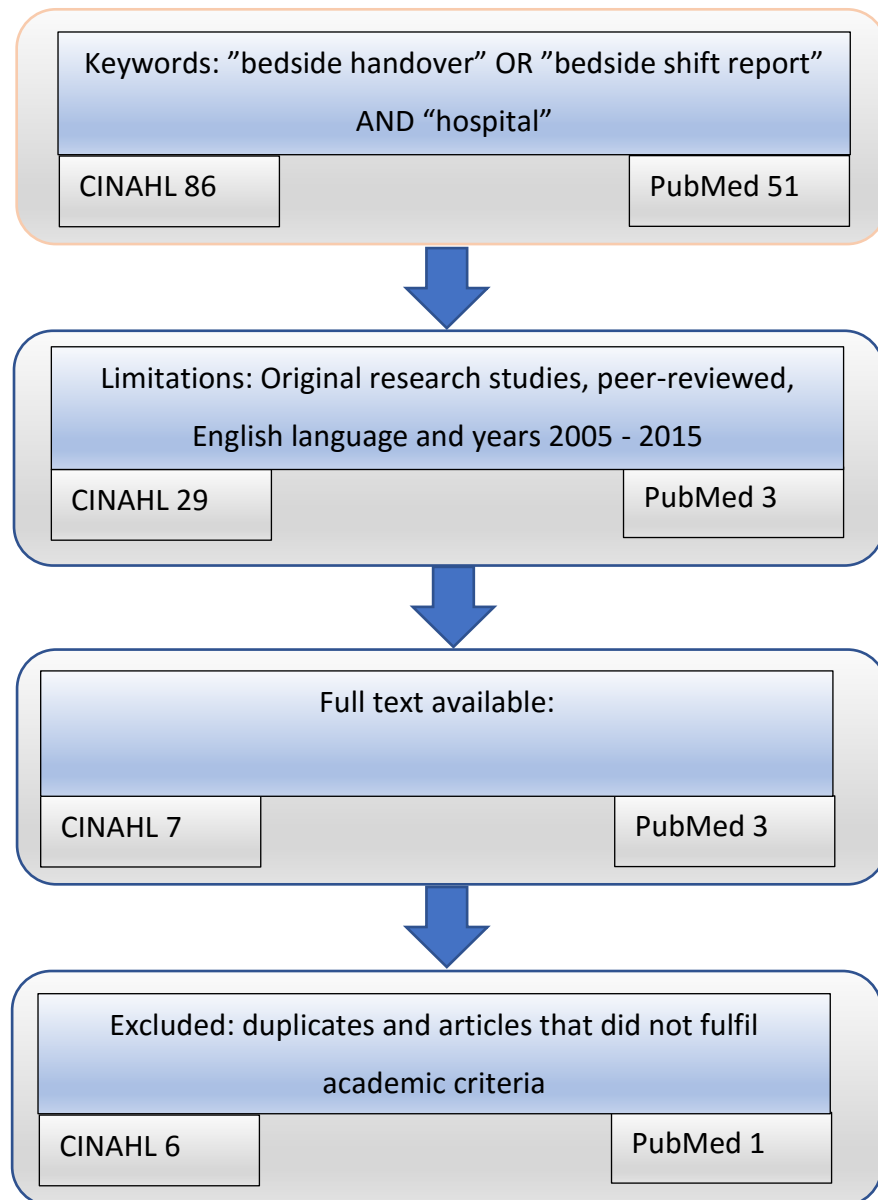


Table 1: Results of search process in numbers

A similar search was carried in the PubMed database; however, it was not possible to use synonyms while carrying out the search. When an initial search containing the keywords "bedside handover" was used, there was a total of 51 articles. The search criteria for articles that were written in English and were published between 2005 and 2015 were then applied. The search returned only 3 articles. While reading through the three articles on PubMed, it also suggested some links to related articles which however, were not accessible.

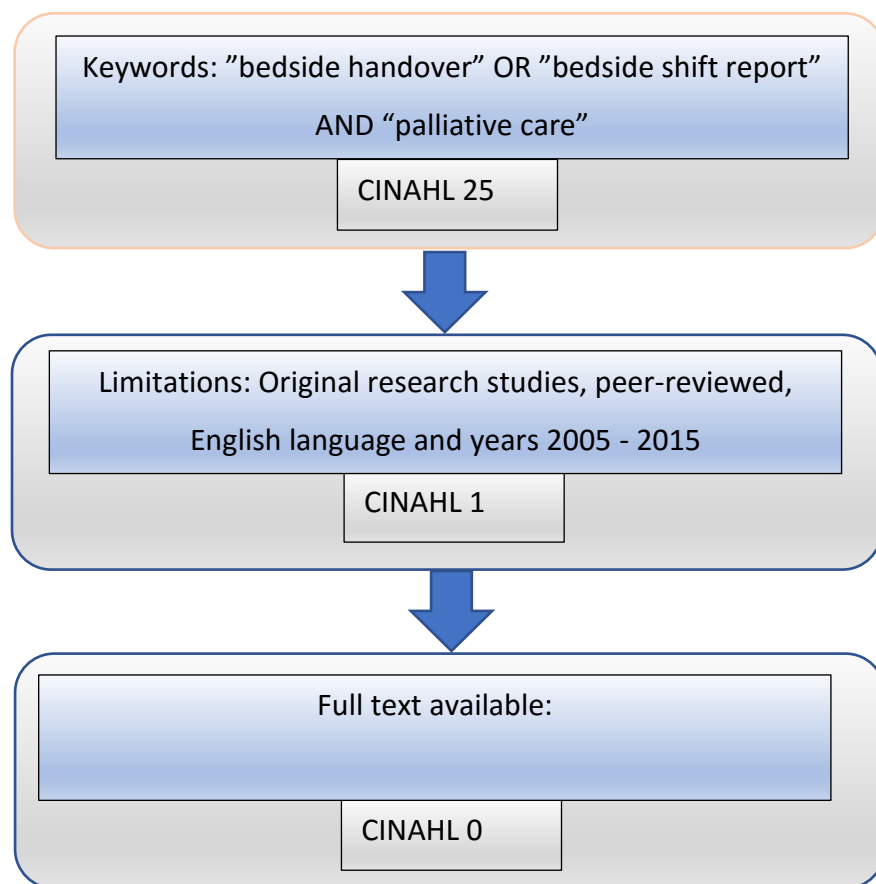


Table 2: Results of search process in numbers

Table 2 shows the search which was carried out in CINAHL using the keywords “bedside handover” or “bedside shift report” and “palliative care” and it produced a total of 25 articles. The criteria for original research studies which were peer-reviewed, written in English language and published during the years 2005 to 2015 were then applied. This resulted in only one article, which unfortunately, did not contain full text.

#### 4.4 Description and appraisal of data

There was a total of seven articles that fulfilled the research study; six articles were from CINAHL and one from PubMed. Four of the researches in CINAHL had been conducted in Australia, one in the USA and one in Germany. The only research article in PubMed had been conducted in Australia. The studies were published in 2012 (2), 2014 (3) and 2015 (2). The categories of the reports were: two surveys, one experts’ article review, one observation method, one literature review, one questionnaire and one mixed method study.

In one study, nurses working in an Intensive Care Unit (ICU) of a hospital were observed during bedside handovers. In another study, nurses’ and patients’ preferences during nursing bedside handovers were discussed. A third and fourth study focused on patients’ and family members’ points of view respectively. Another study concentrated on the perspectives of different health professionals while the last two studies considered the views of both nurses and patients.

#### 4.5 Analysis of data

The method chosen for analysing data was a qualitative research. Qualitative researches are comprised of a wide variety of perspectives and methods for the study of natural social life. The information that is collected and analyzed in qualitative researches is mostly nonquantitative in character. (Saldana 2014, 3.) A systematic review, which is a type of qualitative research, was applied in collecting and analysing information for this thesis. Webb and Roe (2003) state that the purpose of systematic reviews is to identify researches that are relevant to a

particular question, appraise and assess their suitability, and summarise them using statistical methods to combine their results, if applicable and appropriate (3).

According to Pope, Popay, and Mays (2007), content analysis is used to combine findings from relevant researches, identify dominant subjects and then make generalisations. This information is categorized in a systematic manner into themes and the frequency with which each theme occurs is then counted. (48.) Thematic analyses identify the main recurrent themes that arise from several studies relating to the research question, group them together and then summarize the findings (ibid., 96).

## 5 Results

### 5.1 Themes and subcategories

The results seemed to support the literature that was previously presented. The main findings were divided into three main themes which were further divided into subcategories. The first theme considered the experiences of nurses, mainly, and other health care professionals. The second theme discussed the patients' experiences while the last theme considered the family members' experiences. Table 3 below shows the main themes and their subcategories.

Confidentiality	Nurses, other healthcare professionals Patients Family members
Patient/carers involvement	Nurses Patients Family members
Shared decision-making	Nurses, other healthcare professionals Patients Family members
Amount of time spent on bedside handovers	Nurses Family members
Interruptions	Nurses, other healthcare professionals
Lack of standardized procedures and handover tools	Nurses
Inadequate training and lack of confidence in carrying out bedside handovers	Nurses, other healthcare professionals
Use of clinical jargon and abbreviations	Nurses

Table 3. Themes of main findings and their subcategories

## 5.2 Results

### 5.2.1 Confidentiality

Anderson, Malone, Shanahan, and Manning (2014, 669); Evans, Grunawalt, McClish, Wood, and Friese (2012, 283); Spinks, Chaboyer, Bucknall, Tobiano, and Whitty (2015, 3); Tobiano, Chaboyer, and McMurray (2012, 196); Manias, Geddes, Watson, Jones, and Della (2015, 88) conceded that nurses expressed more concerns regarding maintaining confidentiality during bedside handover reports than patients and their families. Köberich (2014, 832) stated that some nurses were concerned regarding patient information confidentiality.

Nurses commonly voiced their concerns about maintaining confidentiality while carrying out bedside handover reports as there often were other patients in the room. This concern was mainly due to the legal obligation for health care professionals to observe and maintain privacy and confidentiality of patient information. (Anderson et al. 2014, 669.) Evans and others (2012, 283) stated that potentially sensitive or confidential information was often discussed in a private room, which was away from the patients' bedside. According to Anderson and others, (2014), such practices undermined bedside handovers, as they often excluded the patient and family members (669).

Köberich (2014, 832) noted that some patients began to view issues related to confidentiality information as vital after the implementation of bedside handovers at a university affiliated heart centre, compared to before bedside handovers were implemented. Tobiano and colleagues (2012) stated that families did not raise concerns about confidentiality of patient information during bedside handovers (196).

### 5.2.2 Patient/carers involvement

Bedside handover reports improved communication between nurses and patients and helped to ensure that patients were more involved in their care. On-coming nurses were introduced, which enabled patients to identify the nurses who were responsible for their care during the shift. (Anderson et al. 2014, 669); (Evans et al.

2012, 292.) Involving patients in their care and enabling them to identify the nurses who were responsible for their care during the shift increased patient satisfaction (Evans et al. 2012, 292).

Patients felt that bedside handovers not only provided them with an opportunity to gain information, but also encouraged them to share information with nurses during the handover process. Patients also felt motivated to take part in their care. However, patients felt that they lacked confidence to participate in bedside handovers if nurses failed to encourage or engage them in the handover process. (Spinks et al. 2015, 3–4.)

Evans and colleagues (2012, 284) stated that bedside handovers increased satisfaction among nurses, enabled nurses to visualize the patients and the environment and make physical checks on fluids and IV lines. This helped on-coming nurses to prioritize for their shifts, ensuring that they first attended to critically ill patients. On-coming nurses were also able to ask questions and clarify issues from patients and fellow nurses. According to Spinks and colleagues (2015), some nurses valued the involvement of patients in bedside handovers as they felt that patients could provide updated information and clarify errors (3).

Manias and colleagues (2015, 88); Tobiano and others (2012, 197) noted that many healthcare professionals valued the input of patients and family members during bedside handovers, as it promoted patient-centred care. However, according to Manias and others (2015), some health care professionals felt that the effectiveness of bedside handover reports was greatly reduced when patients and their families were involved (88). Nurses expressed concerns that patients may disrupt the handover process by asking for something during the bedside handovers (Evans et al. 2012, 284). Some nurses did not motivate patients to participate in bedside handovers because they felt that patients interfered with the handover process (Spinks et al. 2015, 3).

Patients and family members felt that being involved in bedside handovers made them feel acknowledged and respected and that the care they received was individualized (Tobiano et al. 2012, 196). Bedside handovers also provided an opportunity for family members to act on behalf of patients and actively participate



in their care, especially in situations where patients had limited ability to participate. Family members found bedside handovers as effortless ways of being involved in the patient's care. Families were not only able to gain more information regarding the patient's care, but were also able to clarify issues with nurses during bedside handovers. (ibid., 197.)

### 5.2.3 Shared decision-making

According to Köberich (2014), patients' perceptions of shared decision-making rose by eight percent after the implementation of bedside handovers (827). Tobiano and others (2012) stated that family members felt that when nurses encouraged them to ask questions during bedside handovers, they were better informed about the patient's diagnosis, treatment and interventions that were performed (196–197).

Nurses, patients and family members felt that working together was vital, as it helped them to plan for the future. Patients and their families felt that discussing about the discharge process during bedside handovers was crucial in enabling them to make prior arrangements regarding care for the patient at home. (Tobiano et al. 2012, 197.)

Family members expressed feeling confident to share information and their knowledge with nurses during bedside handovers. They perceived bedside handovers as a way of facilitating communication between them and nurses. (Tobiano et al. 2012, 197.)

Conventionally, doctors and nurses make decisions regarding treatments and goals for care with minimal contribution from patients or their families. In these kinds of situations, patients and their families often view doctors and nurses as being authoritative. Bedside handovers, however, challenged the conventional ways of communication between health care professionals, patients and their families as they encouraged transparent communication and cooperation in decision-making. (Tobiano et al. 2012, 197.)

Often, healthcare professionals decided not to discuss sensitive information such as medical errors at the patients' bedside, without consulting with patients nor their families. In this aspect, bedside handovers undermined the process of shared

decision-making and the quality of care that patients and their families received. (Manias et al. 88.)

#### 5.2.4 Amount of time spent on bedside handovers

According to Evans and colleagues (2012), the amount of time it took to give and receive nursing handovers reduced significantly with the introduction of bedside handovers. Nurses spent considerably less time conversing among themselves during bedside handovers. This, in turn, reduced the amount of time it took to give and receive handovers, thus ensuring that off-going nurses finished their shifts on time. With off-going nurses leaving their shifts on time, the amount of overtime reduced considerably. Less incidents of compensation for overtime led to improved budgets for the unit. On-coming nurses were able to prevent delays by making physical checks on patients, fluids and IV lines during bedside handovers. This ensured that they started their shifts promptly. (284–292.)

Manias and others (2015) noted that nurses perceived the inclusion of patients and their families in bedside handovers as increasing the time it took to carry out nursing handovers and to explain information to them. Nurses cited these reasons as obstacles in the involvement of patients and their families in bedside handovers. (88.)

According to Tobiano and colleagues (2012), nurses are often quite busy caring for many patients during their shifts, which means that family members frequently must pursue nurses around the ward to ask questions regarding the patient's care. Family members could plan their visits to coincide with the time that nurses carried out bedside handovers so that they could listen to and participate in the handover process. They therefore viewed bedside handovers as efficient in saving time since they were able to acquire information and ask questions regarding the patient's care while they were visiting. (197.)

#### 5.2.5 Interruptions

In their study in the Intensive Care Unit (ICU) of one hospital, Spooner, Corley, Chaboyer, Hammond, and Fraser (2014) noted that the most casual interruptions came from nurses, medical staff and alarming intravenous pumps. Other sources of

interruptions came from administrative staff and other health care professionals. Interruptions are common among nurses and are widespread practice in most hospital and health care settings. Research states that while some interruptions during emergency and critical situations are necessary, excessive distractions and interruptions can impact negatively on concentration thus undermining the quality of care provided. (21.)

Doctors, nurses and other health care professionals often interrupt each other during handovers to clarify or ask questions regarding patients, procedures or care guidelines. Random, isolated noises can impair concentration, cause a break in the task and lead to critical information being lost or forgotten thereby increasing errors during bedside handover reports. (ibid., 22.)

Evans and colleagues (2012) found that many nurses were not comfortable speaking with their fellow nurses when patients were present. Nurses expressed concerns that patients could interrupt or ask questions during bedside handovers, thus hindering effective communication during the handover process. (284.)

Spooner and colleagues (2014) noted that the frequency of interruptions during bedside handovers differed between patients and during shifts. The more critically ill a patient was, and the more health care professionals from different disciplines working together during the same shift, the greater the number of interruptions. (22.)

#### 5.2.6 Lack of standardized procedures and handover tools

Anderson and colleagues (2014) stated that the use of communication tools during bedside handovers helped to reduce errors by ensuring that all vital information regarding patients and their care was communicated to on-coming nurses during shift changes. Communication tools also discouraged the heavy reliance on memory thus ensuring that the information provided was reliable. (668.)

According to Manias and colleagues (2015), more than half of the health care professionals that participated in the survey used some form of handover communication tools, such as SBAR or ISBAR, while giving handovers (88). Anderson and others (2014, 669); Manias and colleagues (2015, 88) noted that there was a vast

number of clinical handover tools that were available, though however, there was not a single handover tool that suited all areas of clinical practice.

A combination of written notes and verbal communication during bedside handovers was strongly supported by most health care professionals. Nearly half of the doctors that took part in the survey admitted to relying on memory to remember patient information during handovers. This is a practice that was strongly discouraged and was deemed inefficient as it often led to vital information being omitted. (Manias et al. 2015, 89.)

#### 5.2.7 Inadequate training and lack of confidence in carrying out bedside handovers

Köberich (2014), carried out a study at a university affiliated heart centre, which sought to determine whether nursing bedside handover reports influenced patients to participate in their care. The study found that three months after the implementation of nursing bedside handover reports, some nurses still lacked confidence while carrying out bedside handovers and even had defensive attitudes towards bedside handovers. (827.)

Evans and others (2012) also noted that some nurses expressed discomfort with communication while the patient was present (284). Köberich (2014) determined that when some nurses took part in further training to improve their communication skills, they reported feeling more confident while communicating with patients during bedside handover reports (827).

Junior nurses and other health care professionals identified the need to receive feedback from their senior colleagues as a way for them to improve communication while carrying out handovers. They also valued their senior counterparts acting as role models in leadership. Implementation of handover education and training in schools, group activities, multidisciplinary workshops and productive feedback were considered beneficial in improving communication skills among nurses and other health care professionals. (Manias et al. 2015, 89.)

### 5.2.8 Use of clinical jargon and abbreviations

Evans and others (2012) noted that nurses tended to avoid expressing subjective opinions about patients and their families during bedside handovers. This observation was made after the introduction of bedside handover reports. (284.)

The use of clinical jargon, acronyms and abbreviations among nurses also significantly reduced while carrying out bedside handovers. The use of clinical jargon, abbreviations and unfamiliar acronyms while communicating with patients and their families is strictly prohibited by hospital procedures and policies. The researchers stated that these findings, however, needed to be further investigated. (ibid., 284.)

## 6 Discussion

### 6.1 Discussion of the results

The aim of this thesis was to find out the experiences of nurses while giving and receiving bedside handover reports in hospital and hospice palliative care wards. The influences of patients and their families during bedside handovers were also considered.

Palliative care, as a discipline, aims at improving the quality of life of patients and their families. Patient-centred care is emphasized in palliative care, which means that patients and their families are the unit of care. Nurses should provide individualized care to patients and their families which focuses on their needs, goals and expectations for treatment and care.

Patients and their families often rely on nurses to provide physical, emotional, psychological and spiritual support during distressing times. Communicating in an honest and sensitive manner with patients and their families helps to build and maintain therapeutic relationships which are based on trust. Ineffective communication can lead to misunderstandings, resentment and lack of cooperation and deny patients and their families the chance of experiencing death in a dignified manner.

Nursing handovers take place during the change of shifts, where the off-going nurses provide the on-coming nurses with information regarding the condition and the care given to patients and their families. Professional responsibility and accountability for patients and their care are transferred from the off-going nurses onto the on-coming nurses during handovers. Nursing handover reports are often conducted on a one-to-one basis, or in a group setting and are often carried out at ward offices, nurses' stations, along corridors, at patients' bedsides or in halls. Handover reports serve as learning experiences for nursing staff and students and provide them with opportunities to clarify unclear information. There are four main types of nursing handover reports which are namely, verbal, tape-recorded, written and bedside handovers.

Bedside handovers are a form of verbal handover reports which take place by the patient's bedside. The off-going nurse introduces the patient, and his or her family to the on-coming nurse and provides information regarding the goals and the plan of care. Patients and their families have the right to either participate or not during bedside handovers. Patients are often involved in bedside handovers and can communicate their needs and preferences with the on-coming nurses, which allows them to prioritize for the shift.

Bedside handovers can help to reduce errors and increase patient safety, clarify misunderstandings for both patients and healthcare professionals, help patients to adhere to their treatment and care plans and reduce the number of hospital readmissions.

Problems in communication between healthcare professionals or with patients have been sighted as one of the causes of unexpected deaths and serious physical or psychological injuries to patients in healthcare settings. Poor communication also undermines the patients' and healthcare professionals' experiences. There are several factors that can influence communication between nurses or with patients, and their families during bedside handovers.

Sometimes, patients may wish to have some, or all their information remain confidential from their families. Confidential information may include test results, communicable diseases, abuse and do-not-resuscitate (DNR) orders. The more public the environment in which nursing handovers take place, the greater the risk of breaching confidentiality of patient information.

According to the results, nurses expressed more concerns regarding confidentiality during bedside handover reports than patients or their families. Nurses voiced their concerns about confidentiality while carrying out bedside handover reports as there often were other patients in the room. This concern was mainly due to the legal obligation for health care professionals to observe and maintain confidentiality of patient information. Potentially sensitive or confidential information was often discussed in a private room. Unfortunately, discussing sensitive issues away from the patient's bedside often excluded the patient and their families.

One study noted that some patients began to view issues related to confidentiality as vital after the implementation of bedside handover reports, compared to before bedside handovers were implemented. Family members did not raise concerns about confidentiality of patient information during bedside handovers.

Some patients feel that healthcare professionals sometimes fail to ask the relevant questions and that they are too busy to discuss about their concerns with them. Others believe that their concerns are insignificant, or that their concerns will only increase the burden for healthcare professionals.

According to the results, bedside handovers challenged the conventional ways of communication between health care professionals, patients and their families as they encouraged transparent communication and cooperation in decision-making. Patients and family members felt that being involved in bedside handovers made them feel acknowledged and respected and that the care they received was individualized.

Bedside handovers helped to ensure that patients were more involved in their care. However, patients reported that they lacked confidence to participate in bedside handovers if nurses failed to encourage or engage them in the handover process.

Family members perceived bedside handovers as a way of facilitating communication between them and nurses, and as a way of being involved in the patient's care. They felt that when nurses encouraged them to ask questions, they were better informed about the patient's diagnosis, treatment and care. In situations where patients had limited ability to participate, bedside handovers provided an opportunity for family members to act on their behalf.

There were mixed feelings among nurses regarding the involvement of patients and their families in bedside handovers. Most nurses perceived their involvement as beneficial as they could provide updated information and clarify errors. This was viewed as promoting patient-centred care. However, some nurses felt that the effectiveness of bedside handover reports was greatly reduced when patients and their families were involved. Nurses expressed concerns that patients may ask for something, thus disrupting the handover process. Some nurses did not motivate



patients to participate because they felt that patients interfered with the handover process.

For communication between nurses, patients and their families to be effective, all the relevant participants should be present and should allocate enough time for the discussion. If too little time is allocated for discussions, communication tends to be rushed and essential information could be left out.

There were mixed results regarding the amount of time it took to carry out bedside handover reports. One study determined that after the introduction of bedside handovers, the amount of time it took to give and receive handovers reduced significantly. Off-going nurses finished their shifts on time thus reducing the amount of incidental overtime. Less overtime led to improved budgets for the unit.

Another study contradicted these findings as nurses felt that the inclusion of patients and their families increased the time it took for them to carry out bedside handovers. Nurses perceived the increase in time as an obstacle in the involvement of patients and their families in bedside handovers.

Family members, on the other hand, viewed bedside handovers as efficient in saving time since they were able to acquire information and ask questions regarding the patient's care while they were visiting. Family members could plan their visits to coincide with the time that nurses carried out bedside handovers, instead of the usual situations where they must pursue nurses around the ward to ask questions regarding the patient's care.

Hospitals and hospices are public places which are often very busy. Emergencies, noise from machines, telephone calls and interruptions from other nurses, patients and visitors are common. These interruptions can cause poor concentration, leading to misunderstandings and errors occurring.

The results showed that most casual interruptions came from nurses, medical staff and alarming machines. Other sources of interruptions came from administrative staff and other health care professionals. While some interruptions during emergency and critical situations are necessary, excessive distractions and interruptions can impact negatively on concentration thus undermining the quality of

care provided. Random, isolated noises can impair concentration, cause a break in the task and lead to critical information being lost or forgotten thus increasing errors during bedside handover reports.

Structured handovers provide accuracy and clarity. ISBAR, an acronym that stands for Identify, Situation, Background, Assessment, and Recommendation, Read-back, Risk, is a tool for communication that has been adapted in many hospitals and care facilities as the standard format for nursing handovers.

According to the results, the use of communication tools during bedside handovers helped to reduce errors by ensuring that all vital information regarding patients and their care was communicated to on-coming nurses during shift changes.

Communication tools also discouraged the heavy reliance on memory thus ensuring that the information provided was reliable. It was also determined that there was a vast number of clinical handover tools that were available, though however, there was not a single handover tool that suited all areas of clinical practice.

Performing nurse-to-nurse handovers is not taught formally in many nursing schools. Lack of adequate communication skills can lead to misunderstandings and cause vital information to be omitted. Nurses' inexperience and lack of confidence can lead to them feeling intimidated to carry out bedside handovers; some nurses may fail to engage patients in the discussion altogether. Providing relevant training to nurses can help them to gain confidence and improve their competency in carrying out bedside handovers.

According to the results, some nurses expressed feeling uncomfortable to communicate while patients were present. One study showed that three months after the implementation of bedside handovers, some nurses still lacked confidence while carrying out bedside handovers and even had defensive attitudes towards bedside handovers. Additionally, the same study determined that when some nurses took part in further training to improve their communication skills, they reported feeling more confident while communicating with patients during bedside handover reports.

It is widespread practice for health care professionals to use clinical jargon, abbreviations and acronyms while communicating and documenting patient

information. This practice has been widely criticized as it disguises the meanings of words thereby making it difficult for people outside the health care profession to understand. The practice has also been sighted as an obstacle to effective communication, especially among less experienced health care professionals.

The results showed that nurses tended to avoid expressing subjective opinions about patients and their families during bedside handovers. The use of clinical jargon, acronyms and abbreviations among nurses also reduced significantly. The researchers stated that these findings, however, needed to be further investigated.

## 6.2 Ethical considerations

This thesis was written in accordance with JAMK project reporting instructions. The instructions outlined the rules and regulations that were required for writing an academic project. Unethical character such as plagiarism and fabrication of information was strictly avoided by ensuring that the articles that were utilized in the writing process were carefully selected and accurately documented in the report.

Collection of the information was carried out only through authorized official access to JAMK library databases such as CINAHL and PubMed. The articles that were utilized in the writing of the report were carefully checked to ensure that they were original articles and that the authors were acknowledged.

## 6.3 Limitations

During the writing process, the author discovered that using a literature review as the method for gathering and analysing information was quite restrictive. The author was unable to find articles that were directly related to the research question. This led to the conclusion that either, there were very few or no previous researches that had been carried out on the topic or that if there were some research articles related to the topic, they were not accessible for free in neither CINAHL nor PubMed. Consequently, the author resorted to utilizing the articles that were closely related to the research question.

## 6.4 Further developments

Education, creation of training programmes, group activities and multidisciplinary workshops that are focused on handover reporting could be beneficial for improving communication during handovers. Senior health care professionals could be provided with opportunities to act as role models to their junior counterparts. (Manias et al. 89.) Education to improve communication during bedside handovers should be part of the health care institutions plans to provide patient-centred care. Assessment of the handover processes and tools should be further investigated. (Anderson et al. 2014, 669.) Nurses need to be equipped with skills that facilitate effective communication with families. These skills will help them to encourage family members to participate in bedside handovers. (Tobiano et al. 2012, 198.)

Further studies that examine the effects and consequences of interruptions during bedside handovers should be carried out. Ways on how to manage these interruptions effectively should also be considered, to develop and execute interventions that improve patient outcomes. (Spooner et al. 2014, 22.)

Most families would like to be involved in the patient's care thus nurses need to view them as partners in the care process. Strategies that encourage family members to participate in bedside handovers should be considered. Studies that examine whether there are any gender related differences in family members' views of bedside handovers should be further investigated. Family members who participated in the study were close to patients and were involved in their care. The researchers wondered whether the outcomes of their study would have been different, if the participants would have come from a wider variety of relationships between the patients and their families. (Tobiano et al. 2012, 198.)

## 7 Conclusion

Nurses and other health care professionals concur that involving patients and their families is valuable in providing patient-centered care. Bedside handovers provide an opportunity for patients and their families to participate in and influence the care that they receive. Confidentiality while carrying out bedside handovers continues to be a concern among nurses.

Studies show that nurses continue to have divided opinions regarding the involvement of patients and their families in the handover process. Some nurses feel that bedside handovers facilitate communication and encourage cooperation in decision-making. Other nurses, on the other hand, perceive the effectiveness of bedside handovers to be greatly reduced when patients and their families are involved.

Opinions on the length of time it takes to conduct bedside handovers appear to differ among nurses. Some studies indicate that after the introduction of bedside handovers, the amount of time that was spent carrying out handovers reduced greatly. Other studies indicate that nurses perceived the amount of time they spent on conducting bedside handovers increased, compared to other types of handovers.

Interruptions from nurses, patients, family members, other health care professionals and machines are common. While some interruptions during emergencies are necessary, excessive interruptions can cause misunderstandings, poor concentration and lead to errors occurring during bedside handovers. Effects and consequences of interruptions during bedside handovers need to be further investigated.

Education on how to carry out effective handovers should be part of nursing schools and health care institutions training programmes in communication. This would help to ensure that nurses are equipped with skills that facilitate effective communication with other health care professionals, patients and their families.

Nurses who work in hospital and hospice palliative care wards could benefit from the outcomes of this study. The findings could be utilized in the implementation of bedside handovers and in improving communication during bedside handovers.

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## Appendix

Appendix 1 List of articles chosen for the literature review and their contents

Authors & country	Article	Publication	Purpose of study	Research methods	Key findings
Spooner, A. J., Corley, A., Chaboyer, W., Hammond, N. E., & Fraser, J. F.  Australia	Measurement of the frequency and source of interruptions occurring during bedside nursing handover in the intensive care unit: An observational study	Australian Critical Care, 2014, 28(1), 19–23. Elsevier  Australia	To measure the frequency and source of interruptions during intensive care (ICU) bedside nursing handover	20 observations of bedside handover in an ICU were performed on Monday to Friday during night to day shift and day to evening shift changes.  The frequency and source of interruptions for each handover were recorded by the observer	(1) The mean number of interruptions was 2( $\pm$ 2) per handover with a range of 0–7.  (2) Doctors, nurses and alarming intravenous pumps were the most frequent source of interruptions, with administration staff and wards people also disrupting handovers
Anderson, J., Malone, L., Shanahan, K., & Manning, J.  Australia	Nursing bedside clinical handover – an integrated review of issues and tools	Journal of Clinical Nursing, 2014, 24, 662–671. John Wiley & Sons Ltd	To review available literature that supports implementing bedside clinical handover in nursing	A literature review of 45 articles	(1) A number of clinical handover mnemonics are available that provide structure to the process  (2) Areas such as confidentiality, inclusion of the patient/carer and involving the multidisciplinary team

			clinical practice and identify key issues if any		remain topical issues for practitioners in implementing good clinical handover practices
Spinks, J., Chaboyer, W., Bucknall, T., Tobiano, G., & Whitty, J. A.  Australia	Patient and nurse preferences for nurse handover—using preferences to inform policy: a discrete choice experiment protocol	BMJ Open, 2015, 5, 1–8	(1) Identify, compare and contrast the preferences for various aspects of handover common to nurses and patients while accounting for other factors, such as the time constraints of nurses that may influence these preferences (2) Identify opportunities for nurses to better involve patients in bedside handover	A discrete choice experiment (DCE) which uses a survey design common to both patients and nurses	(1) Identifying, comparing and contrasting how different attributes are perceived by patients and nurses and especially to identify any disconnect. (2) Identifying any attributes that may be causing nursing staff not to undertake handover in a manner that encourages patient participation in the bedside handover, as per the recommended guidelines

			(3) Identify patient and nurse preferences that may challenge the full implementation of bedside handover in the acute medical setting		
Evans, D., Grunawalt, J., McClish, D., Wood, W., & Friese, C. R.  USA	Bedside shift-to-shift nursing report: implementation and outcomes	MEDSURG Nursing, 2012, 21(5), 281–292	The primary motivator for this study was staff dissatisfaction with nurse-to-nurse report and the inability to complete the shift at the scheduled end time	A team of unit-based nurses, in conjunction with the unit's nurse manager, clinical nurse specialist, nursing supervisor and educational coordinator was formed to review existing report procedures and propose changes. The team convened an 8hour, non-clinical workday to review available literature regarding best practices in shift reporting, and plan their change. Bedside handovers were identified as one strategy to improve desired outcomes	(1) Average report time for giving reports reduced significantly leading to reduced incidental overtime (2) Nurse satisfaction with report process; nurses were able to prioritize for the shift, visualize patient and environment and make physical checks (3) Many nurses expressed concerns over bedside handovers and patient information confidentiality

Köberich, S.  Germany	Nursing bedside handover does not influence cardiovascular surgery patients' participation in nursing care decision-making process: results three months after implementation	International Journal of Caring Sciences, 2014, 7(3), 823–833	To evaluate the effect of nursing bedside handover on patients' perception of shared decision making in nursing care and the side effects of nursing bedside handover	Single-centre, non-experimental study	(1) There were no statistically significant differences regarding patients' perception of decision-making aspects. Before and after implementation of nursing bedside handover, most patients perceived the style of the decision-making process about their nursing care as paternalistic.  (2) During implementation of nursing bedside handover nurses expressed distress with and showed a defensive attitude toward nursing bedside handover
Tobiano, G., Chaboyer, W., & McMurray, A.  Australia	Family members' perceptions of the nursing bedside handover	Journal of Clinical Nursing, 2012, 22, 192–200	To explore families' perceptions of shift-to-shift bedside handover	8 family members participated in the study in a rehabilitation ward. Data included observations of bedside handover, field notes and in-depth interviews.  Thematic analysis of data was conducted to identify unique and	(1) Understanding the situation, consisted of three subthemes: feeling informed, understanding the patient's condition and understanding patient's treatment  (2) Interacting with nursing staff, with five subthemes, including sharing information, clarifying information,

				common themes indicative of family perceptions	assisting in care, asking questions and interpreting for the patient (3) Finding value, which contained five subthemes: feeling at ease, feeling included, valuing individualisation, preparing for the future and maintaining patient privacy
Manias, E., Geddes, F., Watson, B., Jones, D., & Dela, P.  Australia	Perspectives of clinical handover processes: a multi-site survey across different health professionals	Journal of Clinical Nursing, 2015, 25, 80–91 John Wiley & Sons Ltd	To examine the perspectives of health professionals of different disciplines about clinical handover	Many health professionals reported being aware of adverse events where they noticed poor handover was a significant cause. Differences existed between health professions in terms of how effectively they gave handover, perceived effectiveness of bedside handover vs. nonbedside handover, patient and family involvement in handover, respondents' confirmation of understanding handover from their perspective, their observation of senior health professionals giving	(1) Many health professionals reported being aware of adverse events where they noticed poor handover was a significant cause (2) Differences existed between health professions in terms of how effectively they gave handover, perceived effectiveness of bedside handover vs. nonbedside handover, patient and family involvement in handover, respondents' confirmation of understanding handover from their perspective, their observation of senior health professionals giving

				feedback to junior health professionals, awareness of adverse events and severity of adverse events relating to poor handovers	feedback to junior health professionals, awareness of adverse events and severity of adverse events relating to poor handovers
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